

MEDICAL ASSISTANCE ADMINISTRATION

MAA Medical Assistance Administration

SUPPORTING DOCUMENTATION - STANDARD COVER LETTER

HEALTH PLAN	PRODUCT		
ATTENTION			DATE COVER SHEET PREPARED
Use ONE sheet per submited claim and <u>DO NOT</u> attach a copy of the claim. <u>DO NOT</u> use for a corrected claim OR request for review.			
Original Claim Number (from voucher):			Check here if claim was submited electronically
CLAIM IDENTIFICATION INFORMATION			
PATIENT'S NAME FIRST	MI	LAST	
PATIENT DATE OF BIRTH	DATE(S) O	F SERVICE	
PROVIDER OF SERVICE			TAX ID NUMBER
Subscriber/Member ID number with pefix (when appro	priate):		
SUBSCRIBER'S NAME FIRST	MI	LAST	
PROVIDER OFFICE CONTACT PERSON			
NAME			TELEPHONE NUMBER
OTHER INFORMATION			
LIST OF THE DOCUMENTS YOU ATTACHED:			
PRIVACY STATEMENT			
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